Delivering a Healthy WA

Government of Western Australia
Department of Health
North Metropolitan Area Health Service – Mental Health

REFERRAL FORM

STRICTLY CONFIDENTIAL

ALL REFERRALS MUST BE MADE BY A HEALTH CARE PROFESSIONAL

CENTRALISED TRIAGE & ASSESSMENT SERVICE

CHILD AND ADOLESCENT MENTAL HEALTH

C/- Lakeside Joondalup Shopping Centre, Centre Management Box No.86 Joondalup WA 6027

PH: 9233 9366 / FAX: 9233 9388

Hours of operation are Monday – Friday 9:00am – 5:00pm

CLIENT DETAILS

CHILD/ YOUNG PERSON'S SURNAME: _____ NAMES: _____

IS CHILD/ YOUNG PERSON KNOWN BY ANY OTHER NAMES: _____ DOB: ____ /____ /___

GENDER: FEMALE ☐ MALE ☐ MEDICARE NUMBER: _____Ref:___ Exp:_____

CURRENT ADDRESS: _____ SUBURB: _____ STATE: _____ P/CODE_____

HOME PHONE: _____ MOBILE: _____

ABORIGINAL OR TORRES STRAIT ISLANDER ☐ OTHER ETHNICITY ☐ _____

COUNTRY OF BIRTH: _____ YEAR OF ARRIVAL IN AUSTRALIA: _____

PREFERRED LANGUAGE: _____

INTERPRETER REQUIRED? : YES/ NO REQUESTED GENDER OF INTERPRETER: FEMALE ☐ MALE ☐

CURRENT SCHOOL: _____ YEAR: _____ PHONE: _____

PARENT'S/GUARDIAN'S DETAILS:

PLEASE TICK ALL APPLICABLE BOXES

☐ Father's name: _____ Work phone/mobile: _____

☐ Mother's name: _____ Work phone/mobile: _____

☐ Legal Guardian's name: _____ Guardian's relationship to Child/ Young Person: _____

Have the parents/guardians consented to this referral? YES ☐ NO ☐

If over 16 years, has the child consented to the referral? YES ☐ NO ☐

REFERRER'S DETAILS: (Please write or print clearly):

NAME: _____ ROLE/POSITION: _____

Practice/ Agency name: _____ Tel: _____ Fax:_____

Address: _____ Post Code: _____

Have you directly assessed the child? YES ☐ NO ☐

PLEASE INDICATE DATE OF LAST CONTACT WITH THE REFERRED CHILD/ YOUNG PERSON: ___ /____ /___

MENTAL HEALTH ISSUES – PRESENTING PROBLEMS: (Please write or print clearly)

Describe presenting problems, including onset and duration of problem, and frequency of concern:

_____

_____

_____

_____

_____

_____

_____

_____

_____

IDENTIFICATION OF RISK ISSUES: Do you feel the child is **currently** at risk? YES ☐ NO ☐

Describe issues:

_____

_____

_____

IDENTIFICATION OF CHILD PROTECTION ISSUES: Are there any **unaddressed** concerns, such as abuse, neglect, lack of supervision, homelessness? YES ☐ NO ☐

_____

_____

_____

_____

OTHER AGENCIES/ CARE PROVIDERS INVOLVED: (Current & Previous)

1. _____ Contact person: _____ Phone: _____ When? _____

2. _____ Contact person: _____ Phone: _____ When? _____

3. _____ Contact person: _____ Phone: _____ When? _____

If current are these agencies aware of your referral? YES ☐ NO ☐

(N.B. If reports are available, could you please arrange for these to be forwarded with the referral)

FURTHER COMMENT & RELEVANT MATTERS OF CONCERN:

_____

_____

_____

_____

Thank you for the information provided; a member from our Triage Team will make contact shortly to discuss this referral